INFRARED SYMPATHETIC SKIN RESPONSE STUDIES (THERMOGRAPHY)

Infrared sympathetic skin response (SSR) testing is a diagnostic procedure that utilizes an electronic infrared imaging device to map the skin's galvanic impedance via measurements of surface temperature. The procedure is harmless, non-invasive and does not use ionizing radiation.

Because skin galvonic impedance is controlled by a part of the nervous system called the "sympathetic" system, differences from one side of the body to the other represent abnormalities of sympathetic regulation. When abnormalities are present, in the presence or unusual or unexpectedly severe pain, it is referred to as RSD (reflex sympathetic dystrophy) or CRPS.

SSR studies are objective tests that prove the presence, distribution and type of vasomotor instability. When abnormalities are present direct clinical impacts in decision making (both diagnoistic and treatment) occur.

At   we are committed to the goal of trying to prove why an individual is hurting. We have found SSR studies to be valuable in the diagnosis and treatment of sympathetically mediated pain syndromes. We are also committed to presenting our treatments and diagnostic procedures in an honest fashion. We feel it is necessary to let you know that not everyone believes in sympathetic pain syndromes, or in infrared sympathetic galvonic skin studies for its diagnosis.

Since it varies by payor, we can not guarantee what your insurance company will do in regards to payment for this study. By signing this form, you acknowledge and confirm that you understand this, and agree to pay for services rendered in the event that we determine that your carrier will not pay for services rendered. You also consent to the use of your images for teaching purposes as long as personal identifing information has been removed. If you have any questions, feel free to either contact your carrier directly or to ask our office for assistance.

Self payment amount: ____________

Patient Signature: ________________

____

Physician

Date: ________________

Breast Thermography Consent and Release Form

I hereby acknowledge that I have asked Drs. To perform Breast Thermography studies. Drs. did not solicit or recommend that I do this study instead of or to replace a conventionally accepted Breast Health test.

I understand that Thermal imaging is an examination of physiology that is complimentary to anatomical imaging techniques. Though proven to be highly accurate, thermal imaging is an adjunctive procedure; and as such, it is not intended to replace anatomic studies such as mammography, ultrasound, MRI, CT, X-ray, or others.

I also understand that Thermography utilizes infrared technology which does not see <u>into</u> the body. It does <u>not</u> image any structure deeper than the skin or superficial mucosa. The technology detects heat and measures temperature. A normal thermographic study does NOT necessarily indicate that there is no abnormality and an abnormal study should only be considered as a risk marker. Infrared imaging can only be considered as one part of the evaluative process.

I understand that this is a <u>self-pay, non-refundable</u> examination. I further understand that Breast Thermal imaging may provide more useful information through serial study (no less then annual examinations).

____
Self-Pay Amount

____________________________ ____________________________
Signed Date

____
Witness

Please complete this questionnaire prior to your Breast Thermography evaluation and bring it with you on the date of the examination. Please answer all questions. Use the back if more space is needed.

1) Do you have a personal or family history of breast cancer? ____________________________

If you personally have had breast cancer what was its location?___________________________

2) Are you aware of or have you been told you have any palpable masses?_________________

If so what is its location?____

3) Do you have any nipple discharge, inversion, or changes in the nipples? ________________

If so please describe ____

4) Describe the location and character of any breast skin changes, areas of pain, burning, stinging, tenderness, or achiness ____

5) List any history (include dates and applicable sites) of breast surgery to include implants, lifts, reductions, biopsies, lumpectomies, mastectomies, or revisions and the diagnosis (benign or malignant) ____

6) Provide any history of breast radiation specific as to the site and the time frame (beginning and end) when it was performed____

9) Record any administration of pharmacologic agents for breast cancer____________________

10) List any hormones or birth control pills that you are taking, and their dosages_____________

____.

11) Provide the date and result of the most recent and prior mammogram, most recent breast MRI or ultrasonography, and the location of the breast studied______________________________

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____________________________ ____________________________

Signed Date